DEPARTMENT OF MANAGED HEALTH CARE
CALIFORNIA HMO HELP CENTER
DIVISION OF PLAN SURVEYS

FINAL REPORT

ROUTINE MEDICAL SURVEY

OF

KAISER FOUNDATION HEALTH PLAN, INC.

A FULL SERVICE PLAN

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Final Report of a Routine Medical Survey
Kaiser Foundation Health Plan, Inc.
A Full Service Plan

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EXECUTIVE SUMMARY

The California Department of Managed Health Care (the "Department") conducts a Routine Medical Survey of each licensed health care service plan at least once every three years to evaluate a plan's compliance with the requirements of the Knox-Keene Act ("Knox-Keene" or the "Act"). The survey addresses four areas: Quality Management; Grievances and Appeals; Access and Availability of Services; and Utilization Management. The Department conducted its Routine Survey of Kaiser Foundation Health Plan, Inc. (the "Plan") during late 2005, with visits to the Plan's Southern California Region offices conducted October 24–27, 2005, and visits to its Northern California Region offices conducted November 7–10, 2005.

Background

Kaiser Permanente began in the 1930s as a pre-paid group practice health care plan designed to care for workers building the aqueducts and dams in the Mojave Desert and later the Grand Coulee Dam in Washington State. After World War II ended in 1945, the Plan developed into a community program. Its operations in California are divided into two distinct geographic service areas: the Southern California Region headquartered in Pasadena and the Northern California Region in Oakland.

Southern California Region

The Southern California Region began as a separate Region in 1954 with two medical center sites (hospital and accompanying medical offices) in Fontana and Los Angeles. Growth continued with the addition of medical centers in Harbor City, Panorama City, Bellflower, San Diego, West Los Angeles, Anaheim, Woodland Hills, Riverside, and Baldwin Park.

The Bakersfield area medical offices were added in 1989 utilizing Plan medical offices and Southern California Permanente Medical Group (SCPMG) practitioners, but contracting with community hospitals for in-patient services. In February 1997, the Plan expanded operations into the Ventura and Coachella Valley geographic areas. In these two areas, care is provided through affiliated hospitals and other facilities contracted by Kaiser Foundation Hospitals (KFH) or by the Affiliated Provider Groups. Affiliated Provider Groups, their practitioners, and affiliated facilities in the two areas are collectively referred to as the Affiliated Network Providers.

Kaiser Permanente Southern California (KPSC) is comprised of three closely aligned organizations that serve over 3,000,000 enrollees. The Plan is a nonprofit health maintenance organization that contracts with individuals and groups to provide or arrange comprehensive pre-paid health care benefits. The Plan contracts with KFH, a non-profit public benefit corporation that owns and operates community hospitals, to provide or arrange hospital services for health plan members. The Plan also contracts with SCPMG, a multi-specialty physician partnership, to provide or arrange medical and other health care services for Plan members. Collectively, the Plan, SCPMG, and KFH are referred to as "Kaiser Permanente."

The Plan offers a comprehensive health care delivery system, including ambulatory care, preventive services, hospital care, behavioral health (mental health and substance abuse treatment), home health care hospice, rehabilitation services, and skilled nursing services.

Health care services are provided in 14 geographic areas within KPSC. Medical centers in 12 of these 14 areas are managed by KPSC senior managers and physicians. Two additional geographic areas became available to Plan members beginning in February 1997. In these areas, care is provided by Affiliated Medical Groups/Independent Practice Associations and their practitioners contracted by SCPMG and Affiliated Provider Groups.

Northern California Region

The Plan began in Northern California as a pre-paid industrial health care program during World War II, serving thousands of workers at the Kaiser shipyards in Richmond. At the war's end, the Plan was opened for community enrollment over a service area that included the cities of Richmond and Oakland. In 1946 the service area was expanded across the San Francisco Bay with the opening of medical offices in the City of San Francisco. The first members there were civilian workers from the Hunter's Point Naval Shipyard.

Hallmarks of early growth included: 1) enrollment of the International Longshoremen and Warehousemen Union under a 1950 collective bargaining agreement, and 2) a 1952 Labor Day election in which the United Steelworkers of America endorsed a union contract that added 10,000 new members. By 1953, one of every ten San Franciscans was a Kaiser Permanente member. Since that time, Northern California has prospered and grown to a present-day membership that exceeds 3,000,000. Members currently receive care in facilities extending from Fresno to Santa Rosa, and from Sacramento to San Jose.

As is true in the Southern Region, the Plan is comprised of three closely aligned organizations. These organizations are the Plan, KFH, and The Permanente Medical Group (TPMG). The Plan contracts with KFH to provide or arrange hospital services for health plan members. The Plan contracts with TPMG, a multi-specialty physician corporation, to provide or arrange medical and other health care services for Plan members. Within the Northern Region, the Plan has grouped the various medical centers into 12 geographic areas for administrative and customer service purposes. It offers a comprehensive health care delivery system, including ambulatory care, preventive services, hospital care, behavioral health, home health care hospice, rehabilitation services, and skilled nursing services.

Survey Results

The Department found one deficiency identified during the previous 2002 Routine Medical Survey and outstanding from the Follow-Up Review (See Section IIA, Table 3). At the time of this current Routine Survey, the Department found this deficiency had been corrected.

In the Plan's Southern California Region, the Department identified two compliance deficiencies during the current Routine Medical Survey (See Section II, Table 5). The Plan has implemented corrective actions and has fully corrected these deficiencies at the time of this Final Report.

In the Plan's Northern California Region, the Department identified one compliance deficiency during the current Routine Medical Survey (See Section II, Table 8). The Plan has implemented corrective actions and has fully corrected this deficiency at the time of this Final Report.

See Appendix A for an explanation of the Department's approach in surveying California health plans licensed by the Department.

SECTION I: SURVEY HISTORY

Table 1 below is a schedule of survey activities conducted by the Department at the Plan in the past three years.

TABLE 1

SURVEY ACTIVITY	DATE
2002 Routine Survey Onsite Visit	Southern Region: November 4–8, 2002 Northern Region: November 18–22, 2002
2002 Preliminary Report	July 28, 2003
Final Report for 2002 Routine Survey	October 24, 2003
Follow-up Report Issued to Plan	April 26, 2005
2005 Routine Survey Onsite Visit	Southern Region: October 24–27, 2005 Northern Region: November 7–11, 2005
2005 Preliminary Report Issued	January 27, 2006
Final Report for 2005 Routine Survey	April 24, 2006

Table 2 below lists recent enforcement action(s) taken by the Department based on completed investigations where sufficient evidence was found to support allegations that the Plan has committed violations of the Act.

TABLE 2

CITATION	VIOLATION AND ENFORCEMENT ACTION	DATE OF ENFORCEMENT ACTION
Complaint No. 266720 **Citation(s):** Section 1368.01(a) Rule 1300.68(d)(3)	A plan must resolve grievances within 30 days and a written response to the grievance must be sent to the enrollee within 30 days. In this case the enrollee filed a grievance with the Plan on June 2, 2005. The Plan responded to the enrollee by letter dated August 2, 2005, a period of 60 days.	November 9, 2005
Complaint No. 228124 **Citation(s):** Section 1368(a)(5)	The Plan failed to provide a clear explanation of the reasons for its decision and include the Evidence of Coverage (EOC) provisions that apply to a coverage denial.	July 7, 2005

CITATION	VIOLATION AND ENFORCEMENT ACTION	DATE OF ENFORCEMENT ACTION
Complaint No. 234953 **Citation(s):** Section 1368.01(a) Rule 1300.68(d)(3)	The Plan failed to resolve the grievance within the statutory time frame of 30 days, and did not notify the complainant of the status of his grievance within 30days. The Plan acknowledged its failure to resolve this grievance, and failure to notify the complainant in this case of their decision within the statutory time period.	July 7, 2005
Complaint No. 149419 **156087** **196937** **209775** **Citation(s):** Section 1368.01(a) Rule 1300.68(d)(3)	These four complaints involve the Plan's failure to resolve grievances within 30 days and provide a written response to an enrollee's grievances within 30 days.	April 22, 2005
Complaint No. 216180 **Citation(s):** Section 1368(a)(5)	The Plan did not reference the provision of the EOC upon which it based its decision to deny the enrollee's request. The Plan acknowledged its violation.	April 5, 2005
Complaint No. 187521 **Citation(s):** Section 1368(a)(5)	Plans are required to provide a clear and concise explanation of the reasons for the Plan's response. This explanation is for either "medical necessity" or "coverage" issues. In this case the Plan had failed to provide the requisite explanation in notifying the enrollee that the health care services requested were not a covered benefit.	February 3, 2005
Complaint No. 157799 **Citation(s):** Rule 1300.68(g)(1-5)	In this matter, the enrollee filed a grievance with the Department on January 21, 2004. On January 22, 2004, the Department sent notice to the Plan of that grievance and requested information. The Plan provided a timely response; however, the Plan failed to provide all the required information, as required by the cited section. The Plan acknowledged its violation.	January 4, 2005

SECTION II: DISCUSSION OF SURVEY DEFICIENCIES AND CORRECTIVE ACTIONS

A. RE-ASSESSMENT OF OUTSTANDING DEFICIENCIES

Table 3 below presents the deficiency that was outstanding at the time of the previous Follow-Up Report dated April 26, 2005. This deficiency was re-assessed during the current Routine Medical Survey and had been corrected.

TABLE 3

SUMMARY OF 2005 OUTSTANDING DEFICIENCIES				
#	DEFICIENCY STATEMENT	Date Identified	April 2005 Follow-Up Review	Oct.-Nov. 2005 Routine Survey
	GRIEVANCES AND APPEALS			
7	**The Plan does not provide the complainant with a written statement on the disposition or pending status of an urgent grievance within three days of receipt.** [Rule 1300.68.01(a)]	November 2002	Not Corrected	Corrected

The following discussion provides details of the Department's findings about the above deficiency.

Deficiency #7: The Plan does not provide the complainant with a written statement on the disposition or pending status of an urgent grievance within three days of receipt.

Criteria: Rule 1300.68.01(a)

Documents Reviewed:
- Policy and Procedure: Complaint, Grievance, and Appeal Process & Resolution, 50-2
- Policy and Procedure: Expedited Review Process & Resolution, HPMR-5
- Sample EOC/Disclosure Form
- Expedited Appeals Case Files, So. CA Region: 12 cases dated 4/1/05 through 9/30/05
- Expedited Appeals Case Files, No. CA Region: 13 cases dated 4/1/05 through 11/7/05

Background of Deficiency:

2003 Routine Medical Survey (Final Report Issued October 24, 2003): The Plan revised its workflow and added resources to its Expedited Review Unit to meet the requirement that members are notified of the disposition or pending status of expedited grievances within three

days of receipt. The Plan submitted its Complaint, Grievance, and Appeal Process & Resolution procedure, effective January 1, 2003, which included these revisions.

2005 Follow-Up Review (Report Issued April 26, 2005): The Department reviewed the Plan's expedited grievance logs and determined that 57 out of 1,085 of the expedited grievances were not handled within three days of receipt; consequently, these enrollees were not notified of the disposition or pending status of their urgent grievances within the required timeframe.

Current Conditions:

Southern California Region – The Plan responded in writing within three days to all 12 expedited appeal cases reviewed by the Department.

Northern California Region: The Plan responded in writing within three days to all 13 expedited appeal cases reviewed by the Department.

TABLE 4

FILE TYPE	# OF FILES REVIEWED	CRITERIA	# COMPLIANT	# DEFICIENT
Expedited Appeals – Southern CA Region	12	Written response within three days	12	0
Expedited Appeals – Northern CA Region	13	Written response within three days	13	0

Department's Findings Concerning Plan's Subsequent Compliance Efforts:

STATUS: SOUTHERN CALIFORNIA REGION – CORRECTED

NORTHERN CALIFORNIA REGION - CORRECTED

The Department finds that this deficiency has been corrected in both the Southern and Northern California regions.

B. 2005 SURVEY DEFICIENCIES

Sections 1 and 2 below address the deficiencies found during the current Routine Medical Survey. The Plan received a Preliminary Report regarding these deficiencies. In that report, the Plan was instructed to: (a) develop and implement a corrective action plan (CAP) for each deficiency, and (b) provide the Department with evidence of the Plan's completion of or progress toward implementing those corrective actions. The "Status" column describes the Department's findings regarding the Plan's corrective actions.

1. SOUTHERN CALIFORNIA REGION

Table 5 below lists deficiencies identified during the current survey in the Plan's Southern Region.

TABLE 5

SOUTHERN CALIFORNIA REGION FINDINGS

#	DEFICIENCY STATEMENT	STATUS
GRIEVANCES AND APPEALS		
1	**The Plan does not consistently provide immediate notification to the complainant of his/her right to contact the Department regarding an urgent grievance.** [Section 1368.01(b) and Rule 1300.68.01(a)(1)]	Corrected
UTILIZATION MANAGEMENT		
2	**The Plan does not consistently notify the requesting provider of the name and telephone number of the health care professional responsible for a denial, delay, or modification.** [Section 1367.01(h)(4)]	Corrected

The following details the Department's preliminary findings, the Plan's corrective actions and the Department's findings concerning the Plan's compliance efforts.

GRIEVANCES AND APPEALS

Deficiency #1: **The Plan does not consistently provide immediate notification to the complainant of his/her right to contact the Department regarding an urgent grievance.**

Criteria: Section 1368.01(b) and Rule 1300.68.01(a)(1)

Documents Reviewed:
- Policy and Procedure: Complaint, Grievance, and Appeal Process & Resolution, 50-2
- Policy and Procedure: Expedited Review Process & Resolution, HPMR-5
- Sample EOC/Disclosure Form
- Expedited Appeals Case Files, So. CA Region: 12 cases dated 4/1/05 through 9/30/05
- Expedited Appeals Case Files, No. CA Region: 13 cases dated 4/1/05 through 11/7/05

Conditions: In five of the 12 expedited appeal case files reviewed by the Department in the Plan's Southern California Region, the Plan notified the enrollee of the outcome of the appeal within 24 hours. In the remaining seven, the Plan did not immediately inform the enrollees of

their right to contact the Department regarding the urgent grievance. In ten of 13 expedited appeal cases reviewed in the Northern California Region, the Plan did not immediately inform its enrollees of their right to contact the Department regarding the urgent grievance.

TABLE 6

FILE TYPE		CRITERIA	# COMPLIANT	# DEFICIENT
Expedited Appeals – Southern CA Region	12	Inform complainant of right to contact the Department	5	7
Expedited Appeals – Northern CA Region	13	Inform complainant of right to contact the Department	3	10

Implications: Failure to immediately notify a complainant of his/her right to contact the Department regarding an urgent grievance may prevent the enrollee from seeking available assistance from the Department in cases involving imminent and serious threat to one's health. The Department may act on the enrollee's behalf to facilitate an expeditious resolution to a grievance or an appeal to prevent delay of necessary service.

Corrective Action: The Plan shall submit evidence that it consistently notifies the complainant of his/her right to contact the Department regarding an urgent grievance.

Plan's Compliance Effort: The Plan stated in its response that it had revised its procedures to require Expedited Review staff, upon receipt of an expedited review, to immediately contact the member by telephone, notify the member of his/her right to contact the Department regarding an urgent grievance, and document this communication in the Member Complaint Tracking System case notes. Additionally, the Plan trained the Expedited Review staff on the requirements of Health and Safety Code 1368.01(b) and the procedural changes.

The Plan submitted the following documents:

- Member resolution letters for an expedited case
- Summary report for a case in which consideration under the expedited review process was denied
- A copy of the Plan's revised Expedited Review Process & Resolution

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

Based upon the corrective actions undertaken, the Department has determined that the Plan has adequately addressed this deficiency.

The Department finds that the Plan has revised its procedures, re-trained staff and demonstrated through provision of sample case files that the revised procedures have been implemented.

UTILIZATION MANAGEMENT

Deficiency #2: The Plan does not consistently notify the requesting provider of the name and telephone number of the health care professional responsible for a denial, delay, or modification.

Documents Reviewed:

- Ten medical necessity denial files dated from 3/30/05 to 7/18/05.

Criteria: Section 1367.01(h)(4)

Conditions: Plan staff confirmed that of ten medical necessity denial files reviewed by the Department eight did not provide the requesting provider, either in the denial notification letter or the fax cover sheet, the required name and telephone number of the physician that made the Utilization Management (UM) decision.

TABLE 7

FILE TYPE	# OF FILES REVIEWED	CRITERIA	# COMPLIANT	# DEFICIENT
Medical Necessity Denial Files	10	The denial letter sent to the requesting provider must include the printed name and direct telephone number of the health care professional who made the denial decision.	2	8

Implications: The absence of the name and telephone number of the health care professional making the denial decision in the denial letter is a significant barrier to the requesting provider's ability to contact the decision-maker expeditiously to discuss the decision. Delay in resolution of a denial may occur, which may also lead to a delay in an enrollee receiving medically necessary and covered services. This is particularly important when additional information from the requesting provider might affect the decision.

Corrective Action: The Plan shall submit evidence that all denial notifications to the requesting provider include the name and telephone number of the physician making the UM decision.

Plan's Compliance Effort: The Plan stated in its response that it had developed template fax forms to be sent to the requesting provider with every denial notification. The template forms include the name and telephone number of the health care professional responsible for the denial. The So. California Assistant Director of Regional Utilization Management and the Senior Consultant provided training to UM staff regarding the need to provide, in writing, the name and phone number of the decision-making physician to the ordering physician in medical necessity denial determinations. The cover sheet was disseminated to all UM areas responsible for mailing denial notices, including: the Regional Utilization Compliance and Consultation Unit, Centralized

Outside UM, decentralized outside UM departments, Emergency Prospective Review department and Durable Medical Equipment department for each medical center. The Plan also conducted post-implementation monitoring, during which it identified the need for a distinct cover sheet for the Durable Medical Equipment departments (which was implemented) and confirmed that all areas were utilizing the cover sheet.

The Plan submitted the following documents:
- Four fax cover sheets
- Associated denial notifications

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

Based upon the corrective actions undertaken, the Department has determined that the Plan has addressed this deficiency.

The Department finds that the Plan has implemented a template fax form that includes the required information, provided training to appropriate staff and demonstrated through provision of sample cases that the revised forms have been implemented.

2. NORTHERN CALIFORNIA REGION

Table 8 below lists the deficiency identified during the current survey in the Plan's Northern Region.

TABLE 8

NORTHERN CALIFORNIA REGION FINDINGS

#	DEFICIENCY STATEMENT	STATUS
GRIEVANCES AND APPEALS		
3	**The Plan does not consistently provide immediate notification to the complainant of his/her right to contact the Department regarding an urgent grievance.** [Section 1368.01(b) and Rule 1300.68.01(a)(1)]	Corrected

The following details the Department's preliminary findings, the Plan's corrective actions and the Department's findings concerning the Plan's compliance efforts.

GRIEVANCES AND APPEALS

Deficiency #3: The Plan does not consistently provide immediate notification to the complainant of his/her right to contact the Department regarding an urgent grievance.

Criteria: Section 1368.01(b) and Rule 1300.68.01(a)(1)

Conditions: This Deficiency was identified in both the Plan's Northern and Southern Regions. Please see discussion under Section B.1, beginning on page 7 for further deatils.

Plan's Compliance Effort: The Plan stated in its response that it had revised its procedures to require the Expedited Review staff, upon receipt of an expedited review, to immediately contact the member by telephone, notify the member of his/her right to contact the Department regarding an urgent grievance and document this communication in the Member Complaint Tracking System case notes. Additionally, the Plan trained the Expedited Review staff on the requirements of Health and Safety Code 1368.01(b) and the procedural changes.

The Plan submitted the following documents:
- Copy of a member resolution letters on an expedited case
- Revised Expedited Review Process & Resolution

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

Based upon the corrective actions undertaken, the Department has determined that the Plan has addressed this deficiency.

The Department finds that the Plan has revised its procedures, re-trained staff and demonstrated through provision of sample letters that the revised procedures have been implemented.

C. SURVEY CONCLUSION

The Department has completed its Routine Medical Survey of the Plan. Based on the results of this survey Final Report, there will be no Follow-Up Review of the Plan conducted.

A P P E N D I X A

A. OVERVIEW OF THE MEDICAL SURVEY PROCESS

The medical survey is a comprehensive evaluation by the Department of a health plan's compliance with the Act and its resulting performance in meeting the health needs of plan enrollees. The survey includes an on-site meeting, a review of documents and interviews with the plan's staff. It also includes a review of the plan's oversight of the plan's provider network. Generally, the Department evaluates a plan's performance in four major areas:

(1) **Quality Management** – Each plan is required to assess and improve the quality of care it provides to its enrollees. During the medical survey, the Department evaluates a plan's quality management program, including:

- Design, implementation and effectiveness of the internal quality of care review systems;
- Overall performance of the plan in providing health care benefits;
- Overall performance of the plan in meeting the health needs of enrollees; and
- Mechanisms for credentialing and peer review.

(2) **Grievances and Appeals** – Each plan is required to resolve all grievances and appeals in a professional, fair and expeditious manner. The Department regards a plan's grievances and appeals process as a core mechanism through which enrollees can exercise their rights should there be a need to resolve problems with their plan. During the medical survey, the Department evaluates a plan's grievances and appeals system, including:

- Design, implementation and effectiveness of the Grievances and Appeals system;
- Procedures for addressing the linguistic and cultural needs of its enrollee population as well as the needs of enrollees with disabilities such as those with visual or other communicative impairment;
- Documentation, investigation and resolution of all forms of grievances and appeals;
- Notification to enrollees, their designees and providers of the disposition of the grievances and appeals; and
- Compliance with timeliness standards.

(3) **Access and Availability of Services –** Each plan is required to ensure that its services are accessible and available to enrollees throughout its service areas and that services are available without delay that may be detrimental to enrollees' health. During the medical survey, the Department evaluates a plan's:

- Procedures for obtaining health care services;
- Procedures for monitoring and ensuring geographic access;
- Procedures for monitoring and ensuring appointment availability; and
- Overall performance in meeting established access and availability standards.

(4) **Utilization Management** – Each plan manages the utilization of medically necessary services through a variety of cost containment mechanisms while ensuring access and quality care. During the medical survey, the Department evaluates a plan's utilization management program, including:

- Procedures for reviewing authorization requests and regulating utilization of services and facilities;
- Compliance with notification and timeliness standards;
- Use of appropriate criteria or clinical guidelines to guide authorization decisions; and
- Use of utilization data to identify and analyze patterns and trends for potential over-utilization or under-utilization of services and to institute corrective actions as necessary.

Following a routine medical survey, the Department provides a plan with a Preliminary Report of its deficiency findings. A plan is required to respond in writing within 45 days of receipt of the Preliminary Report and to submit evidence that the deficiencies have been corrected within the same 45-day response. For those deficiencies that cannot be corrected within the 45-day response period, a plan is required to submit a corrective action plan for Department approval. The Department then provides a Final Report to the plan and makes the report available to the public by mail or on its website (www.dmhc.ca.gov) within 180 days of the last date of the onsite survey. The Final Report contains the survey findings as they were reported in the Preliminary Report, a summary of the plan's response and the Department's determination concerning the adequacy of the plan's response.

The Department conducts a Follow-Up Review and issues a report within 18 months of the date of the Final Report to determine whether uncorrected deficiencies identified in the Final Report have been corrected. The Department then provides a Follow-Up Report, which contains the Department's determination concerning the outstanding deficiencies. If deficiencies identified in the Final Report are not corrected at the time of the Follow-Up Review, a plan may be subject to disciplinary actions pursuant to Health and Safety Code 1380(i)(l). (See Appendix G for additional details on the reporting and response process.)

A P P E N D I X B

B. OVERVIEW OF PLAN OPERATIONS

The table below summarizes the information submitted to the Department by the Plan in response to the Pre-Survey Questionnaire:

PLAN PROFILE

Southern California Region

Type of Plan	Full Service		
Service Area(s) *(Counties, in full or in parts)*	Orange Los Angeles Imperial	Kern Riverside San Bernardino	San Diego Ventura

	Product Lines	**Enrollees**
Number of Enrollees as of 12/31/2004	Kaiser Permanente Traditional Plan Commercial (51+ members)	2,146,192
	Kaiser Permanente Traditional Plan for Small Businesses Small Group – Commercial	276,294
	Kaiser Permanente Pacific Health Advantage Small Group – Pac Advantage	14,412
	Kaiser Traditional Plan for Small Businesses Small Group – Cal Choice	12,664
	Kaiser Permanente Deductible Plan Small Group – Deductible Plan	1,222
	Kaiser Permanente Senior Advantage – Medicare Advantage Group	129,575
	Kaiser Permanente Medicare Cost – Medicare Advantage Individual	176,970
	Kaiser Permanente Medicare Cost – Medicare Cost Group	2,712
	Kaiser Permanente Medicare Cost – Medicare Cost Individual	370
	Kaiser Permanente Personal Advantage Commercial – Individual Plan	153,500
	Kaiser Permanente Conversion Plan Individual – Conversion Plan	15,751
	Kaiser Permanente HIPAA Individual Plan Individual HIPAA Plan	1,757

Number of Enrollees as of 12/31/2004 **(continued)**	Permanente Deductible Plan Individual – Deductible Plan Kaiser	3,947
	MediCal	50,392
	STEPS Dues Subsidy	6,948
	MRMIP	2,923
	KP Cares for Kids Child Health Plan	8,112
	Healthy Families	49,194
	Access for Mothers and Infants (AIM)	700
	Kaiser Permanente Insurance Company (KPIC) PPO/POS	3,885
	Total	3,057,520

	Primary Care	**Specialty Care**		**Affiliated Medical Groups or IPAs**
Number of Providers	2,132	Group SCPs	2,605	1
		Network SCPs	304	
		Direct Contract SCPs	1,241 SCP with groups not individual practitioners	

Northern California Region

Type of Plan	Full Service		
Service Area(s) *(Counties, in full or in parts)*	Alameda Amador Contra Costa El Dorado Fresno Kings Madera Marin	Mariposa Napa Placer Sacramento San Francisco San Joaquin San Mateo Santa Clara	Solano Sonoma Stanislaus Sutter Tulare Yolo Yuba

	Product Lines	**Enrollees**
Number of Enrollees as of 12/31/2004	Kaiser Permanente Traditional Plan Commercial Group (51+ members)	2,083,502
	Kaiser Permanente Traditional Plan for Small Businesses Small Group – Commercial	348,991

Number of Enrollees as of 12/31/2004 **(continued)**	Kaiser Permanente Pacific Health Advantage Pac Advantage Small Group	26,177
	Kaiser Permanente Traditional Plan for Small Businesses Small Group – Cal Choice	18,503
	Kaiser Permanente Deductible Plan Small Group – Deductible Plan	1,498
	Kaiser Permanente Senior Advantage Medicare Advantage – Group	152,049
	Kaiser Permanente Senior Advantage Medicare Advantage - Individual	195,675
	Kaiser Permanente Medicare Cost Medicare Cost – Group	9,443
	Kaiser Permanente Medicare Cost Medicare Cost – Individual	2,803
	Kaiser Permanente Personal Advantage Commercial – Individual Plan	194,693
	Kaiser Permanente Individual Conversion Plan Individual Conversion Plan	32,080
	Kaiser Permanente HIPAA Individual Plan Individual HIPAA Plan	3,086
	Kaiser Permanente Deductible Plan Individual – Deductible Plan	3,677
	State Programs - Medi-Cal Medi-Cal Plans	54,116
	Kaiser Permanente STEPS Plan Dues Subsidy	12,399
	MRMIP	2,173
	KP Cares for Kids Child Health Plan	4,929
	Healthy Families Program Healthy Families	30,554
	Access for Infants and Mothers Program AIM	617
	Kaiser Permanente Insurance Corporation PPO/POS	1,166
	Total	**3,178,131**

Number of Providers	**Primary Care**	**Specialty Care**	**Affiliated Medical Groups or IPAs**
	3,709	6,305	1

The discussion below is a brief overview of the Plan's operations in each of the four program areas that were examined during the Department's Routine Medical Survey.

OVERVIEW OF PROGRAMS

QUALITY MANAGEMENT

Southern California Region

The Plan's Board of Directors (BOD) is ultimately responsible for the quality of care and service provided to enrollees. The BOD has delegated authority for quality management to the Quality and Health Improvement Committee (QHIC), which in turn delegates the oversight of quality management activities to the Southern California Quality Committee (SCQC).

The SCQC is co-chaired by the KPSC Vice President of Quality and Risk Management and the SCPMG Assistant Medical Director. The co-chairs are accountable to the KPSC President and the SCPMG Executive Medical Director for overseeing quality processes and initiatives. The KPSC President and Executive Medical Director, through the Plan's Service Area Manager and the SCPMG Area Medical Directors, hold the medical centers accountable for quality of care and service provided to enrollees. The medical centers establish their own quality structures, programs, resources and systems, and appoint at least one (1) physician quality director (SCPMG) and one (1) administrative quality director (KFH) who are accountable for the quality program in the medical center. Annually, medical center quality program descriptions, work plans and evaluations are reviewed against region-wide criteria, approved locally by the medical center leadership, and approved regionally by the SCQC. At the Affiliated Provider Network level, the Affiliated Network Providers Committee reviews the performance of the affiliated providers.

The following quality-related committees report to the SCQC:

- Medical Center Quality Committees
- Quality Executive Support Team
- Clinical Strategic Goals Steering Group
- Southern California Executive Resource Stewardship Committee
- Southern California Integrated Patient Safety and Risk Management Committee
- Regional Credentials and Privileges Committee
- Affiliated Network Providers Activity
- Procedure Outcome Strategy Team
- Regional Services

The Plan has a well-developed quality improvement program. Quality improvement activities include investigating, analyzing, and trending quality of care and service concerns, as well as activities focusing on the measurement and improvement of nationally and regionally determined measures of quality of care and service. Measures of quality of care and service are based on nationally recognized standards of care (such as the Health Employer Data Information Set®

("HEDIS")[1]) and include inpatient, outpatient, and ancillary services. As reported in the 2005 California Cooperative Healthcare Reporting Initiative Quality Performance Report Card, the Plan performed significantly higher than average in most quality performance indicators

The Plan devotes substantial staff, analytical and information system resources to quality management and quality improvement activities. The Plan has earned an excellent accredited status from the National Committee for Quality Assurance[2].

Northern California Region

The Plan/KFH National Governing Board is ultimately responsible for the quality of care and service provided to all Plan enrollees. The Board has delegated authority for quality management to the Kaiser National QHIC, which in turn delegates the oversight of quality management activities in the Northern California Kaiser Plan to the Quality Oversight Committee (QOC).

The Plan has a sophisticated and well-developed quality improvement system. The activities of this system include investigating, analyzing, and trending current quality of care and service concerns. These concerns are identified through member complaints and grievances, significant event monitoring, and provider-initiated quality referrals. Corrective actions are initiated with regard to valid concerns. Validity is determined through peer review, root-cause analysis, and/or other quality-improvement methodologies. Where corrective actions involve systems and procedure changes, the Plan has mechanisms in place to re-measure their impact.

Quality improvement activity also focuses on the measurement and improvement of nationally and regionally determined measures of quality-of-care and service, including the HEDIS® measures. In addition, quality improvement activity includes chronic disease management, clinical practice guidelines, preventative health, and coordination of care.

The Plan devotes substantial staff, analytical and information system resources to quality management and improvement activities. The Plan has earned an excellent accredited status from the National Committee for Quality Assurance.

The 2004 Quality Program Work plan describes goals and objectives for clinical improvement, and the timeframes for monitoring and completing them.

A physician, the Director of Quality Implementation, conducts oversight of the Quality Management program. The Director of Quality Implementation reports to the Associate Executive Medical Director, who chairs the QOC, and is also a physician. At each Medical Center there is a Chief of Quality and Quality Service Leader as well as a Facility Executive Quality Committee. The Facility Executive and Quality Committees report to the regional QOC.

[1] Health Employee Data Information Set ® ("HEDIS") is a set of standardized performance measures designed to provide information to consumers for comparison of the performance of managed health care plans. HEDIS® is sponsored by and is a registered trademark of the National Committee for Quality Assurance (NCQA).
[2] The National Committee for Quality Assurance (NCQA) is an independent, non-profit organization that certifies physician organizations, and accredits managed care organizations and preferred provider organizations.

The QOC members include staff from the Plan, KFH and TPMG. A Physician Associate Executive Director of TPMG and the President of the Northern California region jointly oversee the QOC and are accountable to the national QHIC.

The following is a partial list of quality-related committees that report to the QOC:

- Regional Credentials & Privileges Committee
- Quality Executive Support Team
- Information, Confidentiality, Privacy & Security Group
- Risk Management/Patient Safety Committee
- Resource Management Committee
- Customer Concerns Committee
- Behavioral Health Quality Improvement Committee
- Chiefs of Quality/Quality and Assistant Administrator of Quality and Service

GRIEVANCES AND APPEALS

Southern and Northern California Regions

Both regions follow the same processes for addressing grievances and appeals.

The Plan's Vice-President, Health Plan Regulatory Services is responsible for ensuring the Plan' continuing compliances with Knox-Keene and regulations, including overseeing processes for investigation and responses to enrollee complaints, grievances, appeals, and IMR review decisions. Within the Health Plan Regulatory Services Department, Member Services, Member Relations, Call Center, and Clinical Review units are involved in the enrollee grievance process.

A complaint, grievance, appeal or request for expedited review may originate through the Plan's Internet website, by letter, e-mail, fax, telephone call; by an enrollee or his/her representatives; by referral from the Department or other sources. There are 56 Member Services satellite locations at Medical Centers and facilities where enrollees may file grievances. An enrollee may request services through the grievance process and may also use the grievance process to address issues relevant to third party recovery.

For standard grievances, the Plan's Member Services forwards the grievances to the Medical Center Review Committee for review and determination. The Medical Center Review Committee is comprised of Plan representatives and physicians from TPMG, in consultation with representatives from the KFH and specialists from TPMG. The Medical Center Review Committee is to render a decision within 15 days of receipt of the grievance by Member Services.

If the Medical Center Review Committee denies or modifies a service that an enrollee is requesting because it was not medically necessary, then the enrollee is informed of the denial in writing and given information about his/her appeal rights, including expedited review and the availability of IMR. The notification letter also informs the enrollee that his/her case will be forwarded to the Regional Appeals Committee for reconsideration or appeal. The Regional

Appeals Committee is also comprised of Plan representatives, physicians from TPMG, in consultation with representatives from the KFH and specialists from TPMG.

Time frame for resolving a standard grievance is 30 days unless the enrollee's condition meets the criteria for expedited review, which is to occur within 72 hours. The 30-day time frame includes the time taken by both Medical Center Review Committee and Regional Appeals Committee to review the case.

The Plan provides assistance to enrollees with limited English proficiency or with a visual or other communicative impairment that include access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate.

The Plan's Call Centers have bilingual staffs who speak Spanish; Cantonese, Mandarin and several other common Chinese dialects. Most Plan facilities also have bilingual staff and American Sign Language interpreters who are trained to interpret and explain medical terms and procedures. Language Line services can provide interpreter services in more than 140 languages by telephone. For deaf, hearing and speech impaired, the Plan has telephone-based services the enrollees can use to make appointments or get advice. Telephone calls over the TTY phone numbers will be responded by Plan with TTY text telephone. The California toll-free TTY service also provides services for the hearing and speech-impaired enrollees.

The Plan does not delegate its grievance functions to other organizations.

ACCESS AND AVAILABILITY OF SERVICES

Southern California Region

The Plan has established standards to guide its performance in a number of areas, including:

- The geographic availability of its providers
- The waiting time for emergency, urgent, preventive and routine appointments with Primary Care Physicians
- Waiting time for specialist referrals
- After-hours care
- Telephone availability
- In-office wait time

The Plan monitors its performance against its standards using tools such as:

- Geographic mapping of facility/practitioner locations in comparison with enrollee locations
- Enrollee satisfaction surveys
- Quarterly enrollee complaint volume and trend reports
- Quarterly Regional Access Report to monitor wait days by appointment type access

The Plan uses a number of approaches to promote and improve access to its services, including:

- Requiring corrective action plans of any provider sites which do not meet appointment availability standards
- An information website
- Strong emphasis on culturally sensitive access, including: translation services, recruitment of bilingual staff, cultural sensitivity training for staff and tailored outreaches to various ethnic populations
- Implementation (in progress) of an electronic information management system that will include services such as provider/enrollee messaging, on-line scheduling, electronic medical record, electronic lab results, and enrollee access to health information

Northern California Region

The Plan has established standards to guide its performance in a number of areas, including:

- Geographic availability of its providers
- Enrollee satisfaction (CAHPS[3]) with waiting time for appointments
- Ratios for number of providers to members
- In-office wait time
- After-hours coverage

The Plan monitors and reports its performance against its standards using tools such as:

- Geo-Access mapping
- CAHPS and proprietary enrollee satisfaction surveys
- Enrollee complaints
- HEDIS® performance measure reports
- "28 Day" tracking of appointment availability by department
- Intensified tracking and drill down analysis where issues have been noted (e.g., radiology procedures)
- Call center monitoring
- Inpatient Utilization Rate report
- Referral volume analysis

The Plan regularly reviews its reports, analyzes the causes of any unsatisfactory results, quickly implements corrective action plans to address the issues and continues to track progress until satisfactory results are achieved.

The Plan includes tracking of and addressing access issues as a section of its Quality Work Plan. Objectives, target dates and responsibilities are clearly outlined.

[3] The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Program is a public-private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care.

The Plan uses a number of approaches to promote and improve access to its services, including:

- Provider recruitment efforts
- Outreaches to and translation services for ethnic and cultural sub-populations
- Use of multi-disciplinary teams
- An information website
- Alternatives to office visits (e.g., phone consults, e-consults)
- Provision of Practitioner Performance Reviews (which contain practitioner specific-information and comparative rates on complaints, member satisfaction, quality measures and access measures) to individual practitioners and their supervisors
- Implementation (in progress) of an electronic information management system that will include services such as provider/enrollee messaging, on-line scheduling, electronic medical record, electronic lab results, and enrollee access to health information

UTILIZATION MANAGEMENT

Southern California Region

Approximately 95% of all services provided to Plan enrollees are provided by in-Plan facilities and practitioners. Another 2% of services are provided by the contracted Affiliated Network, which is composed of three medical groups. The remaining 3% of services cannot be provided by the Plan and are provided by specialty contracts.

The Plan has a UM Committee composed of actively practicing physicians. The UM Committee oversees all aspects of the UM Program. A number of specialized subcommittees report to the UM Committee, including:

- Behavioral Health/Addiction Medicine
- Continuing Care/Long Term Care
- Pharmacy and Therapeutics
- Biotechnology
- Transplants

The Plan has a national, corporate committee dedicated to New Technology Evaluation.

In-Plan services do not require UM decision-making -- all services that are covered benefits, ordered by Plan practitioners and provided by in-Plan practitioners and providers are managed through referral with no UM oversight.

The UM Committee has adopted a large number of measures to monitor and manage utilization. These include but are not limited to measures of service utilization at all levels and in all settings of care, HEDIS®/CAHPS measures and in-patient metrics specific to the Plan's facilities and medical centers. The Plan monitors and reports utilization statistics at the medical center level. The Plan intensely monitors the "Performance Imperative" measures, a group of six measures including preventive services and chronic disease process management measures.

A very limited number of services are provided out-of-Plan and require Plan UM decision-making. These include solid organ transplants, bariatric surgery, durable medical equipment and medical supplies and specialty referral services not available in-Plan. The Plan has adopted proprietary criteria and has developed internal criteria for the review and approval of these services. The Plan-developed criteria are established at the national, corporate level based on scientific literature and expert consensus. Proprietary criteria are licensed from national companies. As all services provided in-Plan are managed by referral, no UM criteria are used for the review and approval of in-Plan specialty services.

The Plan delegates UM to three medical groups and one specialty services organization for complimentary and alternative therapies. The plan has a well-developed, comprehensive and ongoing monitoring program for the oversight of the delegates' UM programs. The delegates report to the Plan on a quarterly basis and the Plan conducts a formal oversight audit of the delegates on an annual basis. In general the medical group delegates use UM criteria developed by the Plan. All other criteria used by medical group delegates are approved by the Plan.

Northern California Region

The Plan has a formal utilization review process for select services and procedures, including continued stays in hospitals and skilled-nursing facilities. Most health care services, however, do not require prior authorization or approval by the Plan if an enrollee has the benefit and a Kaiser provider determines that the service or procedure is medically necessary.

UM is a shared responsibility of the Plan, KFH and the Permanente Medical Groups. The functions of the Medical Directors are similar to the functions of health plan medical directors in a non-integrated system.

The Resource Management Committee, a subcommittee of the QOC, ensures that utilization of services is systematically monitored across all levels of care. The Resource Management Committee also provides oversight for accreditation activities and consults with medical center staff on UM issues. The Resource Management Committee reports to the QOC, which oversees UM in the Northern California region.

The Associate Executive Director is the physician responsible for oversight of UM in Northern California. The Associate Executive Director and the Plan/KFH Senior Vice President of Operations oversee UM in the service areas.

UM Directors of the Medical Centers meet monthly to discuss operational issues, develop and approve regional UM policies, and evaluate compliance with regulatory requirements. Regional UM meetings are held quarterly to discuss similar topics.

A P P E N D I X C

C. LIST OF SURVEYORS

The Survey Team consisted of the following persons:

Kaiser South

MANAGED HEALTHCARE UNLIMITED, INC. REPRESENTATIVES	
Jill Sanborn, MPH	Quality Management Surveyor
Erick Davis, MD	Utilization Management Surveyor
Patricia Allen, M.Ed.	Access and Availability of Services Surveyor
Rose Leidl, RN	Grievances and Appeals Surveyor
Bernice Young	Grievances and Appeals Surveyor

Kaiser North

DEPARTMENT OF MANAGED HEALTH CARE REPRESENTATIVES	
Karen Turner	Counsel, Division of Enforcement

MANAGED HEALTHCARE UNLIMITED, INC. REPRESENTATIVES	
Mark Leveaux, MD	Quality Management Surveyor
Laurence Ikeda, MD	Utilization Management Surveyor
Patricia Allen, M.Ed.	Access and Availability of Services Surveyor
Bernice Young	Grievances and Appeals Surveyor

A P P E N D I X D

D. LIST OF STAFF INTERVIEWED

The following key Plan officers and staff were interviewed during the on-site survey at the Plan.

Kaiser South	
Kurt Drumheller	Director, HPRS Member Relations
Kathy Grannan, M.D	Medical Director, Health Plan Regulatory Services
Cheryl McCaughhan,	Asst. Director, Member Relations
Elizabeth Moorehead	Director Regulatory Compliance, Claims Administration
Iris Del Nevo, RN, FNP	Manager, Expedited Review
Susan McGee, RN	Managing Director HPRS, Regulatory Response
Stan Cias	Regional Director, UM
Terri Soto	Assistant Director, UM
Charles Kellerman	MD, Physician Director, Continuing Care
Elizabeth Trueblood	RN, Nurse Consultant, Survey Readiness
Sheila Tucker	Director, Clinical Review
Bruce Locke	MD, Director, Health Plan Clinical Review
John Brookey, MD	Assistant Medical Director, SCPMG
Carolyn Days-Mustille, RNP	Vice President, Quality and Risk Management
Andy Amster, MSPH	Executive Consultant, Quality and Risk Management
Sharon Mesker, RN	Senior Consultant, Quality and Risk Management
Gigi Thurmond, RN	Quality Practice Leader
Helga Fowler	Regional Director Credentialing
Eula Anyiwo	Group Leader, Regional Service and Access Department SCAL
Chong Kim	Consultant, Regional Service and Access Department SCAL

Kaiser North	
Kathy Grannan, M.D	Medical Director, Health Plan Regulatory Services
Iris Del Nevo, RN, FNP	Manager, Expedited Review
Marilyn Ammons	Dir. Member Relations HPRS
Vicki Stanley	Asst. Dir. Member Relations
Christie Larner	Dir. Regulatory Response Unit, HPRS
Sheila Tucker	Dr. Clinical Review
Carey Ross	Consultant, Survey Readiness, HPRS
Pamela Gasper	RN Nurse Consultant, Survey Readiness, HPRS
Melissa Brint	Compliance Director Regional UM
Linda Trowbridge	Executive Director of the Continuum
Dale Grahn, M.D.	Medical Director Resource Management
Paul Feigenbaum, M.D.	Reg. Med. Dir for Hospital and Chief Operating Officer
Susan McGee	Managing Dir. HPRS, Regulatory Response
Martha Sikkens	Director of Survey Readiness, HPRS
Rachelle Scilingo	RN Nurse Consultant, Survey Readiness, HPRS
Dina Hansen	Manager Coverage Decision Support Unit
Mary Ward	Manager Regional Credentialing
Michael Ralston, M.D.	Director, Quality Implementation, TPMG
Shelley Roth	Health Plan Quality Practice Leader, KFHP
Cathy Wada	Regional Administrator of Quality, Northern California
Phil Madvig, M.D.	Associate Executive Director, TPMG
Maria Cobo	RN Nurse Consultant, Survey Readiness, HPRS
Richard Rabens, M.D.	TPMG Physician Consultant Accreditation and Regulation

A P P E N D I X E

E. LIST OF ACRONYMS

Acronyms	Definition
BOD	Board of Directors
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
EOC	Evidence of Coverage
HEDIS®	Health Plan Employer Data and Information Set
KFH	Kaiser Foundation Hospitals
KPSC	Kaiser Permanente South California
NCQA	National Committee for Quality Assurance
QHIC	Quality and Health Improvement Committee
QOC	Quality Oversight Committee
SCPMG	Southern California Permanente Medical Group
SCQC	Southern California Quality Committee
TPMG	The Permanente Medical Group
UM	Utilization Management

A P P E N D I X F

F. APPLICABLE STATUTES AND REGULATIONS

The following are the specific citations used in this Routine Medical Survey Report as the basis for the deficiencies:

OUTSTANDING DEFICIENCIES FROM FOLLOW-UP REPORT

Deficiency#7: **The Plan does not provide the complainant with a written statement on the disposition or pending status of an urgent grievance within three (3) days of receipt.** [Rule 1300.68.01(a)]

Criteria:
Rule 1300.68.01(a)
Every plan shall include in its grievance system, procedures for the expedited review of grievances involving an imminent and serious threat to the health of the enrollee, including, but not limited to, severe pain, potential loss of life, limb or major bodily function ("urgent grievances"). At a minimum, plan procedures for urgent grievances shall include:

(1) Immediate notification to the complainant of the right to contact the Department regarding the grievance. The plan shall expedite its review of the grievance when the complainant, an authorized representative, or treating physician provides notice to the plan. Notice need not be in writing, but may be accomplished by a documented telephone call.
(2) A written statement to the Department and the complainant on the disposition or pending status of the urgent grievance within three (3) calendar days of receipt of the grievance by the Plan.
(3) Consideration by the plan of the enrollee's medical condition when determining the response time.
(4) No requirement that the enrollee participate in the plan's grievance process prior to applying to the Department for review of the urgent grievance.

CURRENT DEFICIENCIES – SOUTHERN REGION

GRIEVANCES and APPEALS

Deficiency #1: **The Plan does not consistently provide immediate notification to the complainant of his/her right to contact the Department regarding an urgent grievance.** [Section 1368.01(b) and Rule 1300.68.01(a)(1)]

Criteria:
Section 1368.01(b)
The grievance system shall include a requirement for expedited plan review of grievances for cases involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. When the plan has notice of a case requiring expedited review, the grievance system shall require the plan to immediately inform enrollees and subscribers in writing of their right to notify the Department of

the grievance. The grievance system shall also require the plan to provide enrollees, subscribers, and the Department with a written statement on the disposition or pending status of the grievance no later than three days from receipt of the grievance.

Rule 1300.68.01(a)(1)
Immediate notification to the complainant of the right to contact the Department regarding the grievance. The plan shall expedite its review of the grievance when the complainant, an authorized representative, or treating physician provides notice to the plan. Notice need not be in writing, but may be accomplished by a documented telephone call.

UTILIZATION MANAGEMENT

Deficiency #2: **The Plan does not consistently notify the requesting provider of the name and telephone number of the health care professional responsible for a denial, delay, or modification.** [Section 1367.01(h)(4)]]

Criteria:
Section 1367.01(h)(4)
Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively or concurrent with the provision of health care service to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding clinical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan

CURRENT DEFICIENCIES – NORTHERN REGION

GRIEVANCES and APPEALS

Deficiency #3: The Plan does not consistently provide immediate notification to the complainant of his/her right to contact the Department regarding an urgent grievance. [Section 1368.01(b) and Rule 1300.68.01(a)(1)]

Criteria:

Section 1368.01(b)

The grievance system shall include a requirement for expedited plan review of grievances for cases involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. When the plan has notice of a case requiring expedited review, the grievance system shall require the plan to immediately inform enrollees and subscribers in writing of their right to notify the Department of the grievance. The grievance system shall also require the plan to provide enrollees, subscribers, and the Department with a written statement on the disposition or pending status of the grievance no later than three days from receipt of the grievance.

Rule 1300.68.01(a)(1)

Immediate notification to the complainant of the right to contact the Department regarding the grievance. The plan shall expedite its review of the grievance when the complainant, an authorized representative, or treating physician provides notice to the plan. Notice need not be in writing, but may be accomplished by a documented telephone call.

A P P E N D I X G

G. THE SURVEY PROCESS AND INSTRUCTIONS FOR THE PLAN'S CORRECTIVE ACTIONS AND RESPONSES

The following provides detail on the required survey activities and the order in which they are undertaken by the Department as well as instructions to plans for instituting corrective actions and preparing their responses to the Preliminary Report and the Final Report. The table below summarizes the survey activities and the corresponding timeframes.

MEDICAL SURVEY PROCESS

SURVEY ACTIVITY	TIMEFRAME
Notification Letter and Request for Documents	Prior to on-site visit
Routine Survey On-Site Visit Conducted	At least once every three years
Preliminary Report due from the Department to the Plan	Within 60-80 days from last day of on-site visit
Response due from Plan to the Department [Section 1380(h)(2)] *(Include evidence that each deficiency has been fully corrected)*	45 calendar days from date of receipt of Preliminary Report
Final Report due from the Department to the Plan	Within 170 days from the last day of the on-site visit
Response from Plan to Department on any matters in Final Report	Within ten calendar days from receipt of Final Report. Response is included in Public File with Final Report
Final Report due from Department to the Public File [Section 1380(h)(1)]	Within 180 days from the last day of the on-site visit
Follow-Up Review Conducted	Anytime within 16 months of date Final Report issued to the Public File
Follow-Up Report due from the Department to the Plan	No later than 18 months from the date of the Final Report issued to the Public File
Response from Plan to Department on any matters in Follow-Up Report	Within ten calendar days from receipt of Follow-Up Report. Response is included in Public File with Follow-Up Report
Follow-Up Report due to the Public File [Section 1380(i)(2)]	No later than 18 months from the date of the Final Report issued to the Public File

Survey Preparation
The Department conducts a routine medical survey of each licensed health care service plan at least once every three years in order to evaluate the plan's compliance with the Act. Prior to the visit, the Department supplies the Plan with a Pre-On-Site Visit Questionnaire and a list of materials that the Plan is required to submit to the Department prior to the on-site visit. These materials are reviewed by the survey team to provide them with an overview of plan operations, policies and procedures in preparation for the visit. The Plan is also advised of the materials (e.g., case files, reports) the surveyors will review during the on-site visit so that these will be readily available for the survey team.

On-Site Visit
During the on-site visit, the survey team reviews materials and conducts interviews with Plan staff and possibly with providers.

Preliminary Report
Within 60-80 days of the on-site visit, the Department provides the Plan with a Preliminary Report, which details its survey findings and the required corrective actions.

Plan's Response to the Preliminary Report
In accordance with Section 1380(h)(2), the Plan has 45 calendar days from the date of receipt of the Preliminary Report to file a written response. Preliminary and Final Reports are "deficiency-based" reports; therefore, only specific areas found by the Department to be in need of improvement are included in these Reports. Omission of other areas of the Plan's performance from the reports does not necessarily mean that the Plan is in compliance with the Act. The Department may not have surveyed these other areas or may not have obtained sufficient information to form a conclusion about the Plan's performance in other areas.

All deficiencies cited in the Preliminary Report require corrective actions by the Plan. The Department specifies corrective actions in cases where factual findings of a deficiency constitute a violation of the Act. The Plan must implement all required actions in the manner prescribed by the Department. The Plan must submit evidence that the required actions have been or are being implemented when the Plan submits its 45-day response.

The Plan's response should include the following information for each deficiency identified in the Preliminary Report:

(1) The Plan's response to the Department's findings of deficiencies;

(2) The Plan's response to the Department's specified corrective actions, which include a corrective action plan (CAP);

(3) Whether the CAP is fully implemented at the time of the Plan's response. If the CAP is fully implemented, the Plan should provide documents or other evidence that the deficiencies have been corrected; and

(4) If the CAP cannot be fully implemented by the time the Plan submits its response, the Plan should submit evidence that remedial action has been initiated and is on the way to achieving compliance. Please include a time-schedule for implementing the corrective action and a full description of the evidence the Plan will submit for the Department's follow-up review that will show the deficiency has been fully corrected.

In addition to requiring corrective actions, the Department may take other actions with regard to violations, including enforcement actions.

The Plan may request that designated portions of the response be maintained as confidential, pursuant to Section 1380(g)(6). If the Plan's response indicates that the development and implementation of corrective actions will not be completed by the time the Plan files its 45-day response, the Plan should file any policies and procedures required for implementation as Plan amendments and/or material modifications pursuant to Section 1352 and Rule 1300.52.4. If this situation occurs, the Plan should file both a clean and redline version of revised policies and procedures through the Department's web portal. The Plan is to clearly note in its response to the Preliminary Report, which is to be submitted via e-mail and hard copy to the Department, that the revised policies and procedures have been submitted to the Department via the web portal. The Plan is not to submit its entire response to the Preliminary Report through the Department's web portal, only those documents that meet the criteria as stated in Section 1352 and Rule 1300.52.4.

Final Report and Summary Report

Upon review of the Plan's response to the Preliminary Report, the Department will publish a Final Report. This report will contain the survey findings as they were reported in the Preliminary Report, a summary of the Plan's response and the Department's determination concerning the adequacy of the Plan's response. Please note that the Plan's failure to correct deficiencies identified in the Final Report may be grounds for disciplinary action as provided by Health & Safety Code Section 1380(i)(1). The Final Report will first be issued to the Plan, followed by a copy to the public file. The Final Report will be issued to the public file not more than 180 days from the conclusion of the on-site survey. The Final Report to the public will be placed on the Department's website: http//www.dmhc.ca.gov/library/reports/med_survey.

The Department will also issue a Summary of the Final Report to the public file at the same time it makes the Final Report available to the public. One copy of the Summary Report is also available free of charge to the public by mail. Additional copies of the Summary Report and copies of the entire Final Report and the Plan's response can be obtained from the Department at cost.

The Plan may submit additional responses to the Final Report and the Summary Report at any time before or after the reports are issued.

Follow-Up Review

The Department will conduct a Follow-Up Review of the Plan and issue a Follow-Up Report within 18 months of the date of the Final Report to determine whether all deficiencies that were uncorrected at the time of the final report have been corrected [see Health and Safety Code

Section 1380(i)(2)]. Please note that the Plan's failure to correct deficiencies identified in the survey report may be grounds for disciplinary action against the plan as provided by Health & Safety Code section 1380(i)(1).